

A Womb of One's Own: Taking Charge of Your Reproduction Without Doctors
by Jane Doe

This book is dedicated to every woman who has ever been forced into a reproductive choice she didn't want to make.

Yes, this means you.

Foreword: Don't Panic

If you're reading this book because you have a political interest in its contents, you are welcome to skip over this part. Some of you, though, are undoubtedly reading not because you're curious, but because you need the information it contains—right now.

The most important thing you can do for yourself if you need information on abortion care (or any other issue involving whether or not to have a baby), is to read this book carefully. Skipping over information could pose a risk to your safety or health. It is important not to double up on doses or change the procedures in this book, which have been based on extensive research.

You may have been told some misinformation about the relative safety of the abortion pill. You may be thinking that simply by purchasing these pills you are putting yourself at legal risk, or that abortion is unsafe. Many anti-abortion organizations have chosen to emphasize the dangers of abortion, but these organizations consistently neglect to mention a simple fact: first trimester abortions, even home abortion with pills obtained on the internet, are significantly safer than births. Second-trimester abortions are slightly safer to equally safe.

There is no 100% safe way to stop a pregnancy once it starts—not through miscarriage, not through abortion, and not through birth. While birth is relatively safe today, abortion is in fact *even safer*—a fact that often gets lost in the rhetoric surrounding issues of reproductive choice.

If you're starting to read this book today, and you are not located near the Mexico border (where pills may be obtained relatively easily), it is likely that it will take you between one and three weeks to obtain your abortion medication. The most important information you need about your pregnancy will be the date that your most recent period started.

This means that you can obtain the pills and have over a week to plan and prepare yourself for your abortion. There is no need to panic, no need to rush, and no need to take shortcuts with your termination. In these pages, you'll learn not only how to terminate your pregnancy, but how to avoid future pregnancies (or even, in the expanded edition, how to increase your fertility in the future, when you would like to carry a pregnancy to term).

While waiting for your pills to arrive, take your time and learn about the procedure you'll be following—what you'll need, what to expect, and how to know if you're experiencing

complications that should send you to the emergency room. You'll be less scared and more empowered to make the decision that's right for you.

I. Introduction

Reproductive choice in the United States today is characterized by a wide gulf between what is legal and what is accessible.

For millions of American women, the ability to choose whether to become pregnant or whether to continue a pregnancy simply does not exist. The number of abortion providers has declined steeply, and “conscience clause” laws have allowed pharmacies to stop stocking contraception and emergency contraception options.

A recent Supreme Court decision got rid of clinic “buffer zones,” which ensures that even women who are able to visit abortion clinics are more vulnerable than ever to taunts, harassment, and physical assault.

Meanwhile, many on the left are unsure of how to stem the rising tide of anti-abortion legislation. Many pro-choice people are still squeamish at the actual idea of abortion—perhaps this includes you, and if so, this guide may be quite eye-opening and give you a better understanding of what we’re fighting for.

In this guide, you won’t find any sugarcoating. I will try to refer to things by their most exact, blunt, plain names: vagina, abortion, The Pill, Plan B. There is nothing shameful—nothing!—about making the choice to abort a pregnancy, and I want to make sure that the information in this guide is conveyed directly, without unnecessary subterfuge.

As someone who has lived in the North and South, the East and West, in cities with millions of others and snowy rural hamlets of a few hundred people, I have seen how access can be limited in many areas and by many factors. This problem is not limited to “red” states where Republicans dominate. Even in liberal states, there are areas with no abortion provider for hundreds of miles. When states combine this geographic spread with restrictions like waiting periods, getting a simple early abortion can cost thousands of dollars including transportation, hotel costs, childcare, and the procedure itself.

No woman—not one—would make the choice to abort in the current conditions, except that they believe themselves to have no other options for aborting safely. I think most women would prefer to receive their abortion pills in their own homes, without having to walk past lines of protesters or hear a speech full of misinformation about fetal pain. Yet this “choice,” in spite of its safety, is not available. Women opt for the choice of going

hundreds of miles and spending hundreds or even thousands of dollars on abortion procedures not because it is ideal, but because there is no other option.

No woman—not one—would make the choice to receive birth control in the current conditions, except that they believe the alternative to be unwanted pregnancy. No woman would choose to be put up into stirrups and given a test totally unrelated to her request for birth control (imagine men being forced to have prostate examinations each year to receive Viagra prescriptions!). We make these “choices” and feel they are liberating only because they liberate us in comparison to having no option at all.

But what if there were other options? What if “choice” wasn’t just a fiction?

Ten years ago, after seeing what was at that time the nation’s most restrictive abortion law being passed in South Dakota (it would later be overturned), I wrote an abortion manual for the women in that state. The manual, which was as much political statement as instruction list, consisted of information on how to provide a dilation and curettage abortion, or D&C, through the first trimester of pregnancy.

Since that time, I have been accumulating information on how women can best manage their own fertility in a number of ways. This knowledge has come from a number of sources. I have used scholar.google.com to keep up to date with the latest information regarding methods of abortion, contraception, and fertility enhancement (fertility enhancement available only in expanded edition).

This research has led me to several conclusions.

The first is that women have had their choices restricted in ways they may not even have contemplated before. In many countries other than the United States, for example, diaphragms are a contraceptive option available without a prescription. What’s more, doctors have been prescribing a method of use for diaphragms in the United States that runs directly contrary to a 30-year body of research indicating that a simpler, cheaper method is more effective and easier for women to use.

The second conclusion is that there is simply no impetus in government to allow women control over our reproductive lives. There is no chance that women will really have a standard of informed choice in the United States in the near future.

For a long time, I was content to simply share this information with friends and acquaintances who needed it. However, after ten years of learning about these methods, I decided it is time to share them with a wider audience.

“My body, my choice” is a slogan long trumpeted by feminist organizations, but it seems like most of that sloganeering has simply been used to solicit more donations for The Way Things Are Done Now.

What would it mean to live in a world where our bodies really were ours—where we could make our choices about reproduction without involving anybody else as a gatekeeper?

What would it be like, a world where every woman had abortion pills in her bathroom cabinet next to her birth control pills—a world where days or weeks of agonizing guilt-trips weren’t necessary to terminate a pregnancy? What would happen if women had access to fertility enhancement information that could make it easier for them to become pregnant when they wanted? What would happen if women could obtain birth control even without a doctor signing off on her desire to have sex without becoming pregnant?

The medical gatekeeper model has become so enshrined that it can be difficult to even think of such a world. But the truth is that abortion, contraception, and fertility enhancement are cheaper, easier, and more reliable than ever in the history of human civilization.

You can’t get an abortion pill for \$20, a fertility medication course for \$50, or a \$5 birth control pill pack over the counter at your local drugstore—but that’s not because they actually cost more. It’s because of the medical gatekeeping associated with these medications that they cost incredible amounts.

No woman should have to pay thousands of dollars to restore her fertility if she has, for instance, polycystic ovarian syndrome. No woman should have to pay thousands of dollars for her abortion. Cheap, effective, well-studied options exist—and the purpose of this guide is to educate you as to what, precisely, those options are.

No choice comes without disadvantages; no choice comes without risk. I will try to detail these risks to the best of my ability in this book, but I will not be able to list them as extensively as, say, the insert from your birth control package. If you choose to use any pharmaceutical methods described in this book for contraception, abortion, or enhancement of your fertility, make sure you fully understand the possible side effects.

While this guide may, of course, be used by women living anywhere, it is geared primarily toward American women. This is because the United States is where I am from, and its laws and regulations are the ones I am familiar with. If you are reading this book from a country other than the United States, please be advised that any information about the legality of medications or procedures may not apply to your location.

These pages will be very frank about reproductive systems and abortion. Any readers who would prefer not to know graphic information about how abortions work (both the

pill-induced kind and the surgical kind) may want to restrict their reading to the first three sections of this guide, which will give you an overview of contraception--both hormonal and non-hormonal--as well as emergency contraception. The chapter on increasing fertility, available in the expanded edition, may also be of interest.

Some readers may question why the expanded edition includes information on how to enhance fertility, as well as information on preventing conception and birth. The answer is that *all* reproductive choices in the United States are becoming, increasingly, something for only the rich to choose. Women's infertility is soaring, and although there are several safe and effective methods that could enable a majority of these infertile women to conceive, they are inaccessible to women who don't have enough money for fertility specialists. I do not believe that women should face financial obstacles to conception. I believe in reproductive freedom, which does not exclusively mean the freedom to terminate a pregnancy.

The information in this guide is not complete, and there are some items I have deliberately chosen to exclude. For example, I will not detail the usage instructions of the several products available for contraception available over-the-counter or through any mail-order pharmacy in the United States (like condoms, vaginal contraceptive foam, etc.). Nor will I be discussing herbal abortion methods, which are substantially more dangerous and painful--and less likely to work--than the procedures I will describe.

Some may worry about the legal safety of me, Jane Doe, the person writing this guide. I will say that in a world where *The Anarchist's Cookbook* and *Steal This Book* (both of which contain information on performing outright illegal and harmful acts) can be sold freely on Amazon.com, I find it hard to believe prosecution would go very far. This book is a political statement, and I trust in our First Amendment free speech protections to allow me to maintain my liberty and safety even while making this information known.

All of the procedure information contained within these pages is readily available through Google searches, but it is not always put into relatively plain English and it often (but not always) assumes that you will have the help of a physician. The single best internet resource for information on self-abortion is womenonweb.org. I am not personally affiliated with the owners of this website, but they have done an incredible service for women in many nations, both by providing misoprostol to women in countries where abortion is against the law and by giving information on how to do a misoprostol-only abortion.

The expanded edition of this book will be available in paper format and e-book format for \$10 in August of 2014, and will include not only an expansion of the information contained here (including a scholarly bibliography for women who want to do more investigation about their options) but also an entirely new section on how to increase your fertility safely and without the aid of a physician.

These are dark days for reproductive justice advocates. It is time to admit that we have, for many women, lost the fight in the legislatures and the courthouses. It is time to take our battle into our homes and into our mailboxes. A revolution in women's choice—a revolution men cannot take away from us—is in your hands today. Spread this book far and wide. You never know who might need it someday.

II. Preventing Conception, Part I: Hormonal Methods

Of all medications that have been approved by governmental authorities in the 20th century, few have caused as much controversy, for as many reasons, as the hormonal contraceptive pill. While countless women have been able to control their fertility successfully through the use of “The Pill,” the religious right has attacked it as no different from abortions. In addition, not all women are able to use hormonal birth control without a range of negative effects, ranging from weight gain to mood swings to heart attacks.

The most dangerous side effects of hormonal contraceptives are all cardiovascular. Hormonal contraception makes blood clot more readily. Because of this, it is important for women with existing cardiovascular risk factors (including a family history of heart disease, high triglycerides, smoking, or high blood pressure) to consider the possibility of these side effects when choosing a method to control their fertility.

This guide does not take a stand in the hormonal contraceptive “debate” except to say that women should be educated about the risks and potential side effects of all medications before use. Many women find hormonal contraceptives to be their most convenient option. Others find them inconvenient or intolerable. Your mileage, as ever, may vary. I believe in making information on fertility control available regardless of method.

The reason we’re starting with The Pill (and other hormonal contraceptives), then, is simple. More women use hormonal contraceptive pills today than any other type of birth control.

For Starters: The Legal Stuff

No contraceptive medication, including hormonal contraceptive pills, is listed as a “scheduled” drug according to the United States government. This is very important, because it makes all the difference for being able to obtain contraceptive pills completely legally from outside the United States.

The United States government currently allows residents to import up to a 90-day supply of any non-scheduled drug from foreign pharmacies. Realistically, they’re also not checking to see if you got a bit more than a 90-day supply, but if you want to keep it totally on the up-and-up, 90 pills (or 3 NuvaRings, or one Depo shot—yes, you can get these online, as well) is your limit.

Appendix A of this document will give you resources on finding your own online pharmacies for purchasing these medications.

There are, of course, risks inherent to purchasing hormonal contraceptive medication online rather than obtaining it from a physician. For instance, sugar pills are cheaper than active pills, and it's always possible you'll be sent inactive pills--or that a vendor will simply take your money and send nothing. In the unregulated mail-order pharmacy market, finding a reputable distributor is key.

The Pill

It is often difficult to find specific name-brand pill packs at online pharmacies. Many will sell only generic versions of medications, and the names may be different from what you are used to. Mini-pills (which contain only one of the two hormones used in most birth control pills) are a little more finicky than traditional pills, and must be taken at the same time each day for maximum effectiveness. All contraceptive pills, even from foreign pharmacies, will come in labeled boxes with inserts describing how to take the medication for maximum effectiveness.

Any traditional birth control pill (i.e. not the single-hormone 'mini-pill') may be used like the brand "Seasonale," which allows you to not have a period for three months at a time. Simply take the active pills (the pills there are three weeks of in your pack), skip the inactive pills (the pills there's one week of), and move on to the active pills in the next pack. Some women notice side effects from using hormonal pills in this way--for instance, "breakthrough bleeding" that is less extensive than a regular period but may occur irregularly, or symptoms they typically associate with PMS lasting for a long time. Others find this to be a convenient way to get rid of their tampons and pads for good. Your mileage may vary.

The Patch and The Ring

Other types of hormonal contraceptives, including NuvaRing and the birth control patch, are also available through these foreign pharmacies and may be used according to package instructions. Typically, these medications also have an "inactive week" like pills. The NuvaRing may be worn continuously for four weeks, and immediately replaced with a new ring, which will for most women prevent periods with minimal side effects.

The birth control patch has been shown to pose a significant risk of blood clots, especially for women with other risk factors. Given what we know of the risks of the patch, I'd advise another method unless some aspect of the patch specifically is significantly more convenient for you.

The Shot

Depo-Provera, often referred to as simply “Depo,” is an injectable contraceptive that works at maximum effectiveness when injected once every 3 months, but which may make becoming pregnant more difficult for several additional months after discontinuing the medication. Users of Depo-Provera have reported more extensive side effects than with many other forms of contraception, including weight gain (sometimes more than 50 pounds), loss of bone density in women who continue use beyond 5 years, and extreme psychological effects.

Regardless of these side effects, there are reasons some women want or need Depo Provera injections. It is highly effective at preventing pregnancy and does not require a woman to remember a daily routine, so it can be useful for women who have a problem with forgetting to take their pills every day.

Depo-Provera also has a singular advantage that many women never have to think about (thankfully): because the only evidence of the injection is a tiny needle mark (usually in the gluteal area), Depo injections can be used by women who are preventing pregnancy without the knowledge of a partner. With nearly 10 percent of women in the United States reporting that their significant others have pressured them to have a baby when they didn't want to, it's important to know about Depo and how it is used. This is the kind of knowledge that could save the lives of women in abusive situations.

Depo-Provera works through an intramuscular injection, and is shipped in pre-dosed, disposable syringes with needles equipped. Because of this, it's actually quite possible to perform a Depo injection at home. Intravenous injections are much more difficult, but in this case it's actually important not to inject into a blood vessel.

There are two main sites for injecting Depo-Provera. The first (and preferred) site is the gluteus maximus muscle, the largest muscle in the body. The muscle extends over the buttock, but the best IM injection site for Depo injections is just above the buttock. That's because the buttock is often covered in a relatively thick layer of fat, and if the injection is not put into the muscle the medication will be significantly less effective.

The biggest problem with this injection site is a simple one: it is nearly impossible to self-inject safely. While you're better off having someone you trust (See: Appendix B, Building Networks of Trust) help you with your injection, self-injection may be necessary for some women, and so a secondary injection site will be introduced. The bicep muscle, located in the upper arm, is an acceptable alternative.

For technique information on performing intramuscular injections, the best place to ask is Google. Video tutorials explaining proper technique with visual aids are abundant, and it's

worth your time to watch a couple of these before you attempt an intramuscular injection on yourself or someone else in your network of trust.

You may experience some soreness for a day or two near the injection site. This is normal and not cause for alarm. It is also normal for your period to become far lighter or even stop altogether—sometimes for up to a year after discontinuing the medication.

III. Preventing Conception, Part II: The Diaphragm

Many women would prefer, for various reasons, not to use hormonal contraceptive methods. These women have several options of varying effectiveness available over the counter in the drugstore, including vaginal contraceptive foam, film, and female condoms.

However, the most effective form of non-hormonal birth control is one that many women regard as part of a bygone era: the diaphragm.

Here are the reasons many women hate diaphragms: They must be inserted somewhat soon before sex, removed only after several hours have passed, and coated in a spermicidal jelly that is the very opposite of sensual. They also require fittings by a qualified gynecologist. And on top of that, they're not very effective!

Here's the biggest secret in contraception: almost everything you know about diaphragms is wrong.

According to research conducted starting in the 1980s and 1990s (after the golden age of diaphragms had passed into memory), diaphragms do *not* require spermicide to be effective. In fact, when medical researchers began investigating, they found that there is a non-spermicidal method of diaphragm use that is *more effective* than the traditional spermicidal method.

According to research (in, among other papers "Effectiveness of the diaphragm, used continuously, without spermicide" by Ferreira et al. [available at scholar.google.com]), the most effective way to use a diaphragm is referred to as "continuous use," or CU. The method works as follows:

Insert the diaphragm. Rinse it once every 24-48 hours to remove any discharge, but not within four hours of sex. Do not use during any heavy flow days of your period.

That's it. No messy spermicide. No decreased spontaneity. No painful, stinging irritation for women with chemical sensitivities.

What's more, the old wisdom that diaphragms required sizing turns out to have not been entirely true, either. While it's true that some women will require, due to anatomical quirks, a smaller or larger diaphragm, over $\frac{2}{3}$ of women can use a diaphragm of a standard 70 mm size according to "Diaphragms in clinical trials: is clinician fitting necessary?" (Mauck, et al.).

In recent years, a new diaphragm called the Caya has been released that provides an ergonomic and comfortable fit that works for almost all women in a single size. Generally, the women the Caya will be unsuitable for will be those for whom it is too large.

Because many countries in Europe allow the sale of diaphragms without a prescription, several websites sell diaphragms with no prescription and will ship them to the United States. At the time of this writing, most diaphragm options, including shipping to the United States, cost about \$50-80.

During the heavy flow days of your period, you can sterilize your silicone diaphragm using boiling water or a soak in drugstore hydrogen peroxide solution, then rinse and reinsert. A diaphragm used in this manner can work as effective contraception for several years. Some women also like to use their diaphragm to ensure mess-free sexual intercourse during menstruation.

Used with the once-daily rinse method, diaphragms have a failure rate of about one to two couples in 100 per year of intercourse, a similar failure rate to some forms of hormonal contraceptives. Because the CU method is much easier to comply with than the traditional use method, it is also more likely to be practiced consistently and effectively.

Cervical caps are another method of non-hormonal contraception. They must be used in conjunction with spermicide, as studies have shown significantly reduced effectiveness without it. Because of their significantly more difficult compliance requirements and their lack of advantages over diaphragms used with the CU method, this guide will not currently recommend cervical caps as a method of protection. However, extensive information regarding their use can be found using Google.

IV. Emergency Contraception

Emergency contraception works by giving the body hormones that are analogous to those produced during pregnancy. This mechanism of action prevents ovulation and is also somewhat effective at preventing implantation of existing embryos.

It is also the same mechanism of action that is used by hormonal birth control pills. In fact, many commonly sold brands of birth control pills can be used off-label as emergency contraception. Because of the way emergency contraception works, its effectiveness depends on two things: where you are in your menstrual cycle and how soon after unprotected intercourse you take the pills. The longer you wait after unprotected intercourse, the less effective emergency contraception will be. However, studies show it can still have some effect for up to five days after unprotected intercourse.

Even if you choose to control your fertility with non-pill methods, it may be worthwhile to obtain a packet of birth control pills. Especially if you have access to free contraception through an insurance plan, it may be significantly more cost-effective to use this method than to purchase Plan B (which I have seen selling for as much as \$65 per packet) over the counter.

The active ingredient in Plan B is 1.5 milligrams (1500 micrograms) of levonorgestrel, an artificial progesterone. Pills like Amethyst, Aviane, Jolessa, Levora, Cryselle, Camrese, Nordette, Seasonale, Trivora, and more contain the same medication, along with other active ingredients.

In the past, Plan B was taken in two doses: a 1.5 mg pill as soon as possible after unprotected sex, and another 1.5 mg pill 12 hours later. However, subsequent research indicated that the first dose, taken alone, was equally effective and had a reduced side-effect profile.

Some pill packs still sell two 1.5 milligram doses of levonorgestrel. Since the only effect of the added dose is to add to gastrointestinal side effects, you may prefer to simply take one pill and keep the other for a rainy day. Waste not, want not.

Not every birth control pill contains the active ingredient in Plan B. If your birth control pill does, you'll see that after the brand name, in parentheses, the word "levonorgestrel" will appear. Contraceptive pills combine levonorgestrel with other hormonal ingredients, and the dose of each ingredient will be listed on your medication packaging.

In order to use a levonorgestrel birth control pill as emergency contraception, you'll want to first compute how many pills you will need to take. First, look how many milligrams of

levonorgestrel are in each pill. For most birth control pill formulations containing levonorgestrel, this will be .5-.6 mg. This means that in order to bring the total amount of levonorgestrel to 1.5mg, you will typically need three pills, taken in a single dose as soon as possible after having unprotected sex. 1.5 divided by the number of milligrams per pill (or 1500 divided by the number of micrograms per pill) will give you the number of pills required.

Round UP, not down: slightly too much medication is better than slightly too little. However, it is unnecessary to use extra pills significantly beyond the 1.5 mg dosage. Many websites containing information on how to use levonorgestrel-containing birth control as emergency contraception say that women should take, depending on the brand of birth control being used, up to twelve total tablets containing .5 mg of levonorgestrel each (divided into two doses). This is unnecessary and may even be harmful. The amount of total levonorgestrel in such a dosage is substantially more likely to cause side effects--mostly of the gastrointestinal variety--without significantly enhancing the ability of the pills to prevent unwanted pregnancy.

It is absolutely essential to make sure you **only use active pills** when using contraceptive pills as Plan B. Most forms of contraceptive pills come in monthly packs that include 21 days of active pills and 7 days of placeholder sugar pills. The three weeks of active pills are generally colored differently from the week of inactive (sugar) pills in the pill packet. Inactive pills have no medication at all, so using them won't help you to prevent a pregnancy.

Users of emergency contraception should know that EC involves the risks of taking any hormonal birth control pill (though the fact that it is taken infrequently and only for a day at a time makes long-term side effects unlikely). Many users report minor gastrointestinal distress or being nauseated. Much less frequently, blood clots have been known to form as a result of the active ingredient in these pills. Blood clots are a serious side effect (possibly even lethal if one dislodges and causes a pulmonary embolism, stroke, or heart attack) but are rare. If you notice severe leg pain, shortness of breath, or any symptoms of a stroke or heart attack after taking emergency contraception, go to the emergency room immediately--these could indicate the formation of a blood clot.

V. Medical Abortion

Two Ways To Terminate

Terminating a pregnancy can be done in two basic ways. Surgical abortion (which can range from early-term vacuum aspiration to late-term dilation and extraction) involves using surgical implements on the uterus itself, while medical abortion involves using chemical agents (pills) that work to terminate a pregnancy.

For several reasons, this guide will focus primarily on medical abortions. Surgical abortions will be covered later, but unless you are a trained medical practitioner yourself, this is the section you'll want to use if you need to terminate a pregnancy.

A drug that causes a pregnancy to terminate is called an abortifacient. Abortifacient drugs have a long and storied history, and most of the earliest abortifacient drugs were herbal concoctions. In fact, women in ancient Rome were said to have used a plant for this purpose so much that it became extinct!

No woman today should use herbs to abort. Let me repeat that: *no woman today* should use herbs to terminate her pregnancy. Many herbal abortion recipes are, in fact, dangerous, and can cause significant digestive distress and worse without doing anything to terminate a pregnancy. Others simply don't work at all.

What *does* work is misoprostol. It is the safest, most effective pharmaceutical abortifacient in the history of the world, and it is available at pharmacies in many non-US countries. What's more, it is unlikely to be banned or restricted in the near future, because it also serves a function as a blood pressure medication for many non-pregnant people. On its own, misoprostol can be expected to terminate around 80-85% of pregnancies. With the addition of another medication (either mifepristone or, in early term pregnancy, methotrexate), this rate of successful termination reaches over 90%.

Why Not Surgical?

Surgical abortions are substantially faster than medical abortions, but require a trained practitioner. In the past, a majority of women seeking illegal abortions have had to resort to finding a practitioner of surgical abortions. Many of these practitioners were insufficiently trained and caused internal injuries or even death.

With a medical abortion, the risks no longer involve perforation of the uterus or post-surgical infection, as they did in the age of illegal surgical abortions. Because the

active ingredient in Cytotec, misoprostol, works by making your uterus cramp and bleed, it is possible that it will cause you to bleed too much. Hemorrhage, which means the profuse loss of blood, is the single greatest danger of a medical abortion.

Surgical abortions also fundamentally require allowing someone else access to your body in an invasive way. A Womb of One's Own aims to liberate women from the need to rely on other people for abortion care.

While I, Jane Doe, have chosen my pseudonym as a nod to the women of the Jane Collective in Chicago, who provided surgical abortions, the Janes were operating in a very different time. Had they known of a safe and efficacious way to abort without the risks of infection and scarring posed by dilation and curettage, they undoubtedly would have used it. We should be grateful in these difficult times that we have a safer option than our foremothers.

Dating Your Pregnancy

Some methods of medical abortion depend on knowing when your pregnancy began. For example, later we'll be discussing an abortion drug that is only useful in the first 9 weeks of pregnancy. But when does that 9 weeks begin? The answer is likely to surprise you, unless you're a pregnancy and birth expert.

When a doctor says a woman is 9 weeks pregnant, he or she is typically referring to the weeks since her last normal menstrual period. This means, rather counterintuitively, that the first two weeks of pregnancy take place before sperm and egg have even met!

Some women's dates are thrown off by a phenomenon known as "implantation bleeding." In very early pregnancy, near the time when the embryo implants into the uterine wall, a small amount of blood spotting can occur. Since this happens near the time the woman's menstrual period would normally take place, some women assume they are simply having a very light, spotty period and don't realize they have missed their cycle until a month later.

This is why it's important to think of when your last normal period, with a normal flow, was. If you are in doubt, don't use Protocol 3 below.

It is important to keep in mind that when it comes to terminating pregnancies, earlier is always better. The earlier your termination occurs, the quicker and less painful it will be, and the more likely it will be that you will have a complete abortion. Incomplete abortion, in which some of the uterine contents are retained (possibly causing side effects), is a greater risk in pregnancies of beyond 12 weeks' gestation.

If you want to be sure about the gestational age of your pregnancy, the only way to be certain is through a sonogram. The doctor or ultrasound technician can make a good estimate of fetal age based on size and developmental level.

However, there is a disadvantage to getting a sonogram: there is now a medical record of your pregnancy. If you are planning to terminate your pregnancy in a state where self-abortion is illegal, this could potentially cause problems for you later on. It is probably best to act as if you are happy about your pregnancy and want to continue it—this way, if the worst happens and your abortion is complicated, you can return to the hospital and claim a miscarriage without anyone suspecting you of desiring an abortion.

If Something Goes Wrong

Because no pregnancy termination (or any other medical procedure) is 100% safe, it is important to know what to do if you have a medical emergency arising from or taking place soon after your medical abortion.

First things first: After you've used the misoprostol, there is no way that the doctors or nurses you see will be able to identify the medication in your blood. There is no blood or urine test that can detect it. A medical abortion looks indistinguishable from a miscarriage from a physician's point of view.

If your medical abortion goes wrong—for instance, if you are bleeding much more heavily than a menstrual period, you have a fever of 101 degrees or more, or you experience moderate bleeding for more than 10 days—you should seek emergency room treatment. In order to avoid being subject to some states' laws against self-termination of pregnancy, do not admit to having taken any abortifacient medication. You should simply say you are having a miscarriage.

When the clinicians ask when your miscarriage began, you can give them the date when you used the misoprostol tablets. Tell them you felt some severe cramping and realized you were bleeding. You can tell them you knew you were pregnant if you prefer, but you may prefer to say you only realized the pregnancy had happened when the miscarriage began (you can always say you've had one before and know what they feel like).

Remember: hemorrhage and infection are nothing to mess with. They are also both incredibly treatable in the hospital. Don't be afraid to seek treatment if your medical abortion goes wrong—just make sure you stay tight-lipped about what caused your miscarriage to begin.

If your pregnancy has not been terminated and the fetus is still alive, you will likely be treated for bleeding during pregnancy and released after some time being observed in the hospital for additional bleeding or other worrying symptoms.

If your termination was incomplete, and your uterus is retaining some of the products of conception even though the fetus is dead, the doctors in the emergency room will perform a vacuum aspiration to remove the remaining contents from your uterus.

The Abortion Drugs

There are several basic abortion drugs you should know about, but the most important one is called misoprostol. Its most common name-brand formulation is referred to as Cytotec. It's used for some heart conditions, and will cause contractions of the uterus. This medication alone will generally expel fetal material very effectively (success rates of nearly 90%) up to 12 weeks after your most recent period.

After this time, aborting with misoprostol becomes somewhat riskier, but is still quite possible. Abortions at up to 24 weeks through vaginal use of misoprostol are conducted in the UK and EU, and some women actually report greater satisfaction.

(<http://www.guttmacher.org/pubs/journals/3613304a.html>).

Misoprostol alone will cause over 80% of pregnancies to terminate within about a day, a success rate that is far higher than any herbal preparation. However, many women would prefer more certainty than 80-85%, and I don't blame them. In order to achieve better results, another medication must be added.

Mifepristone works by preventing the action of progesterone on the body. Progesterone is a "pregnancy hormone," a chemical your body produces to signal and maintain a pregnancy. When you take mifepristone, you essentially are tricking your body into believing that your pregnancy has already ended, allowing it to return to its pre-pregnant state. This means your body will cut off nutrient supplies from the placenta and allow it to detach, and the cervix will prepare for miscarriage.

Mifepristone on its own is not as effective as misoprostol on its own, but together they work to terminate about 90% of pregnancies.

There is a third, less commonly used medical abortion option, and it is one I will detail here in the interest of completeness even though it has several distinct disadvantages over the mifepristone/misoprostol combination.

Methotrexate is most commonly used as an abortion drug during ectopic, or tubal, pregnancies. It works by making your body not respond to folic acid. You may recall that folic acid supplementation in pregnancy works to prevent deformities and pregnancy loss—essentially, methotrexate's action stops cells from dividing correctly, which leads to the rapid death of the fetus. This is why it is used in tubal pregnancies: rather than taking effect on the uterus, methotrexate works directly on the embryo or fetus.

Methotrexate's method of action is only effective for terminating early pregnancies—say before about 9 weeks since a woman's last normal menstrual period. Using it any later than this may result in poor pregnancy outcomes and deformities. Studies have shown that combining methotrexate with misoprostol works approximately as well as combining mifepristone with misoprostol in early pregnancy. If you are unable to obtain mifepristone, but can obtain methotrexate, it may be useful for an early-term abortion. Just keep in mind that if the pregnancy is not terminated, the methotrexate could cause irreversible damage to the fetus.

What Do I Need?

For the best chance of terminating your pregnancy, you will need **Protocol 1**:

800 micrograms of misoprostol
200 milligrams of mifepristone

Alternately, you may choose to use **Protocol 2**:

800 micrograms of misoprostol (alone)

In **early pregnancy only** (less than 9 weeks since your last normal period), you may opt for **Protocol 3**:

800 micrograms of misoprostol
75-100 milligrams of methotrexate (the typical dose is 50 milligrams per square meter of body surface area. An average woman's body surface area is 1.6 square meters.)

For all medical abortion protocols, the following followup protocol is advisable to have on hand:

800 micrograms of misoprostol

Because medical abortions almost always cause painful cramping, you may also want to have pain medication on hand. Typically, whatever you find most effective for menstrual cramps will be useful here as well. Acetaminophen (Tylenol), naproxen (Aleve), and ibuprofen (Advil) are all excellent options. Heat, such as from a heating pad or hot water bottle, may also be useful in relieving the pain from misoprostol cramping.

Approximately one quarter of women receiving medical abortions in clinics opt to use an opiate medication to manage their medical abortion pain. While these medications are typically scheduled and therefore not legal to obtain without a prescription, you may (like

many Americans) already have some on hand. A normal dose of acetaminophen, an NSAID like naproxen or ibuprofen, or opiate painkillers will not make any impact on the efficacy of your abortion.

You will also want to have sanitary pads available for your use, even if you normally use a tampon, menstrual cup, or menstrual sponge. Due to the risk of infection, it is important not to introduce items to the inside of the vagina while your medical abortion is taking place. Sanitary pads allow this bleeding to take place without putting you at risk.

Protocol 1

This is the gold standard, the most effective of medical abortion regimens. If you are able to obtain both mifepristone and misoprostol, you will have a very good chance of a complete and quick termination, especially in the first 12 weeks of pregnancy.

First, you'll take the 200 milligrams of mifepristone. This is an oral dose: simply take the medication as you would any pill, swallowing it with some water.

Six to eight hours later, you will want to administer the misoprostol pills. In order to maximize the chance of a successful termination and minimize side effects, the best way to do this is to insert the pills vaginally. The vaginal mucosa (the tissues surrounding your vagina) will dissolve and absorb the pills.

To administer the 800 micrograms of misoprostol vaginally, simply take each tablet one at a time and insert it as deeply as possible into your vagina, near the back of the vaginal walls.

Protocol 2

Insert the 800 mcg of misoprostol vaginally as instructed above, omitting the mifepristone step.

Protocol 3

If your methotrexate is in pill form, take it orally. If it is in injection form, follow the instructions for an intramuscular (IM) injection described in the above section on Depo-Provera shots.

Forty-eight hours after you have used the methotrexate (either injected or orally), insert 800 mcg of misoprostol into your vagina.

How Much Will It Hurt?

Typically, you can expect cramping pain to begin around 1-3 hours after you took the misoprostol pills. Cramps may be severe, though they will generally become significantly less painful after the pregnancy tissue has been passed.

Pain is inherently subjective, and cultural and psychological factors matter a great deal to the experience of abortion pain. In general, being informed and having a good understanding of the procedure and what it is likely to feel like will help to diminish fear responses that would otherwise make the pain worse.

While the worst of the cramps should subside within a few days, you may experience residual cramping for up to six weeks. As long as this cramping is not accompanied by excessive bleeding (see the section “How Much Bleeding is Too Much?” below), you can consider it a normal part of the medical abortion process.

You may also experience some amount of emotional and psychological distress. For some women, terminating a pregnancy is an extremely emotionally fraught decision, and it is a choice that is rarely made lightly. If you feel depression, guilt, and so on in the weeks immediately following your medical abortion, it may be due (in part or in whole) to your body’s hormones returning to their pre-pregnancy levels. Some women find that this triggers a temporary hormonal emotional response that can be similar to post-partum depression.

Emotional symptoms lasting beyond a few weeks are unlikely to be caused directly by the physiological hormone changes. If you experience long-lasting emotional pain due to your abortion, you may want to seek counseling. Avoid counseling at so-called “crisis pregnancy centers,” which are generally staffed by unqualified, untrained activists with a religious agenda. A traditional talk therapist can help you to discuss any unresolved feelings about your abortion and help you to heal.

How Much Bleeding Is Too Much?

Since the main dangerous side effect of misoprostol abortion is hemorrhage, but all misoprostol abortions cause some amount of bleeding, it is natural to wonder: how much is too much?

One good way to gauge how much you’re bleeding is to see how many sanitary pads you’re going through. While it may seem like a large amount of blood, it is normal during the heaviest part of a medical abortion to be soaking through up to two super/overnight sanitary pads every hour. If you are soaking through more than two pads per hour for more than two hours in a row, you should seek medical attention.

Blood clots, as well as the products of conception, are normally passed during a medical abortion. It is generally a good idea to keep track of the products of conception, so that you can be sure they have all been voided from your body. Some blood clots you pass may be quite a bit larger than during a typical period—this is not usually cause for alarm, unless you continue to pass them frequently.

The Followup Protocol

Sometimes, a single dose of misoprostol is insufficient to trigger pregnancy-ending cramps. However, a followup vaginal dose of 800 mcg of misoprostol may be effective. Typically, you'll want to wait 5 days after attempting a medical abortion using misoprostol to use the followup protocol.

If you felt nothing at all—no cramps, no bleeding, nothing—there's a very good chance you were given inert pills by your overseas pharmacy. See Appendix A for more information on the best ways to avoid scam pharmacies and how to limit your chances of something going wrong with your pills.

Do not use the followup protocol if you are experiencing severe bleeding (hemorrhage). Instead, you need to visit a hospital. See the “If Something Goes Wrong” section above. Keep in mind that some ordinary miscarriages, especially later ones, also involve bleeding that won't stop. A doctor will not be able to tell that you have performed a self-termination unless you tell them so—and anyone who tries to pressure you into revealing your abortion is not on your side. Your medical care will be the same for a “missed miscarriage,” in which the fetal tissue hasn't been expelled, as it will be for an incomplete misoprostol abortion. The only difference is that the former won't get you into any legal trouble, while the latter might.

FAQ: Medical Abortion

What is the difference between a medical abortion and Plan B?

Plan B only works in a narrow window before an egg is released or an embryo is implanted. By the time you have a positive pregnancy test result, it is far too late for Plan B to be effective. If regular contraception is Plan A and emergency contraception is Plan B, consider a medical abortion “plan C.”

How pregnant is too pregnant to terminate a pregnancy medically?

In the United States, misoprostol/mifepristone abortion is performed only on pregnancies of less than 9 weeks' gestation. However, pregnant women can safely terminate

pregnancies through the 24th week of gestation using misoprostol. This has been shown by a number of European studies, where abortion via misoprostol is offered as an option in many countries throughout the second trimester of pregnancy.

While the ostensible reason for limiting the gestational age in the United States is safety, second trimester and late first trimester abortions are still quite safe with misoprostol. However, the earlier the abortion is performed, the safer it will be. The medications are also more effective when used earlier—a small percentage of women will find that misoprostol is insufficient to terminate their pregnancy, and this percentage grows with fetal age. Later in this FAQ, we'll cover what to do if a medical abortion goes wrong.

What about after 24 weeks?

Allow me to be quite blunt and clear here in the interest of free distribution of information: there is no particular reason that the method outlined here wouldn't work at even later phases of pregnancy. However, in later phases of pregnancy, the result of using misoprostol will be not an abortion, but a live birth of a premature and potentially medically needy infant.

Even in the 22-24 week timeframe, it is possible to experience a live birth of a baby (albeit one that will generally not survive long). This is an emotionally challenging and legally difficult situation, and one that needs to be kept in mind by any woman considering using a medical abortion in late-stage pregnancy.

Should I use misoprostol vaginally or orally?

While studies have shown that the effectiveness of misoprostol varies only slightly depending on whether it is ingested or used vaginally, vaginal administration seems to have a slight edge on oral administration in most comparisons. To be on the safe side, it's probably best to use vaginal administration. However, if this is potentially uncomfortable or traumatic, oral administration will still be highly effective.

Why would I want to add mifepristone to my misoprostol dose?

When women see that the cost of mifepristone is significantly higher than that of misoprostol, many wonder if the drug is necessary at all. It is true that misoprostol alone will successfully terminate a first-trimester pregnancy at least 85% of the time. However, adding mifepristone in the correct dosage can bring those chances to the 95% range for first-trimester pregnancies.

If you are unable to obtain mifepristone and want to terminate your pregnancy, misoprostol alone gives you a very good chance. Consider mifepristone an optional add-on that can give you additional peace of mind.

What does having a medical abortion feel like?

Misoprostol works by causing the uterine muscles to contract. This leads to cramping sensations and bleeding. Many women also experience symptoms like nausea and light-headedness. Some women also experience emotional symptoms, both because of hormone fluctuations and because of the psychological difficulty involved in making the decision to terminate a pregnancy.

You may feel relatively severe cramping sensations. This is caused by the uterus contracting upwards, allowing the cervix to dilate and the fetal tissue to pass through. You may want to keep a non-steroidal anti-inflammatory drug, like ibuprofen or Naproxen, on hand in order to make the cramping more manageable.

What else can I do to prepare?

Some women are able to continue with their daily activities throughout most of the abortion process, but most prefer to spend the days they are experiencing the heaviest bleeding at home, with a hot pad to relieve cramping. If it's possible for you to take time off work, it's probably a good idea.

Pamper yourself in the way you might for a difficult period—if particular scents, foods, television shows, or music can help you to relax during tough menstrual cramps, you may find them valuable during the medical abortion process as well.

What will the fetal tissue look like when it comes out?

This depends completely on how advanced your pregnancy is. In the earliest stages of pregnancy, it may be fairly difficult to distinguish the products of conception from blood clots. As a pregnancy continues, however, the fetus becomes more identifiable. Because of this, it is important to give some consideration to what you might do with the fetal tissue when it passes.

The safest and easiest way to dispose of remains that are relatively small is the toilet. Burial works for larger remains—make sure you dig a deep enough hole that animals will not be able to get into it. If you are self-aborting in a state where self-abortion is criminalized, you should not flush fetal remains down the toilet or bury them immediately. Instead, soak the products of conception in a bucket of bleach overnight--this will make DNA evidence much more difficult to obtain.

How do I know if I need to seek medical attention for complications?

If your bleeding is excessive—which requires bleeding through more than two overnight-style maxi pads per hour for more than two hours, or having continuous, heavy period-like bleeding for longer than two weeks—you should seek the help of a physician. Hemorrhage is nothing to mess with.

Another complication possibility is infection. While medical abortions do not commonly result in infection, any time the cervix is open (for instance, to expel the products of conception) there is a greater-than-usual chance for unfriendly microbes to take up residence. If you experience sensations of warmth or pain that seems to be different from cramping, or have a high fever in the days after your misoprostol abortion, it is important to seek medical attention in case you have developed a uterine infection. Miscarriages can also result in the same complications, so you should be safe in telling a doctor that you are miscarrying a wanted pregnancy, even in states where self-abortion is forbidden.

VI. Surgical Abortion

For a long time, the gold standard of abortion was the surgical abortion. Often performed with dilators and curettes or, more recently, vacuum aspiration systems, surgical abortions still hold a few key advantages over their medical counterparts. Perhaps the biggest of these advantages is duration: while the abortion itself may last hours or days after misoprostol is administered, early vacuum aspiration abortions and D&C procedures last only a few minutes and are quite safe.

About a decade ago, I produced a manual for performing a dilation and curetteage abortion. However, I will not reproduce that manual in these pages. My reasoning is simple: for an untrained person, it is far safer to work within the confines of pharmaceutical abortion than it is to venture into invasive procedures with a concomitant risk of infection, lacerations, and so on.

It is possible when using a medical abortion method that the abortion will not be “completed”—in other words, that not all of the fetal tissue, placenta, and so on will be ejected by the body. When this happens, bleeding can persist and infection can take hold. When this happens, the typical treatment given in an emergency room is either a dilation & curetteage or vacuum aspirator procedure—which are also the two most common surgical abortion procedures.

However, let me make this perfectly clear: it would be downright stupid for a home practitioner to attempt to surgically complete an incomplete misoprostol abortion. Infection complications and inflammation mean that you need a professional. This is not the time to gamble with your life.

Appendix A: Finding an Online Pharmacy

One thing I'm not going to do in this guide, in particular, is give URLs for specific online pharmacies. I have several reasons. First, I don't want anyone thinking this is being done to shill for an online pharmacy. Second, the quality of foreign pharma companies can vary, and companies can go out of business. I don't want to have to update this every time a website goes under. Third, I think it's important for women to develop the information literacy needed to find a reputable site and make their own connections--if everyone uses the sites I provide, it's possible they'll run out or face political pressure to stop providing the medications I've discussed in this guide.

Pharmacies for Abortifacients and Hormonal Birth Control

If you want to do a web search, don't search for things like "mifepristone no prescription" or "misoprostol without rx." These kinds of searches tend to bring up spammy sites that are more likely to be scams that take your credit card information and run. In order to find a legitimate provider of mifepristone or misoprostol, my advice is to start with web forums. For instance, drugbuyersguide.net offers a forum with information about international pharmacies—but don't just stop there.

On these forums, you'll want to look for pharmacies that are well-rated by forum members and which lose packages only occasionally (due to the difficulties of transporting mail worldwide, no online pharmacy has a perfect delivery record).

Occasionally, forum members in these types of forums will go so far as to have their drugs tested for purity and dosage. The people most likely to do this kind of testing are trans people—many trans men and women buy their hormones from online so that they will not need to deal with medical gatekeeping. Since they're spending a lot of money over the course of many years, testing medications (which can cost upward of \$1000 per test) can still be cost-effective.

While transgender hormone medications are not the same as the medications you'll be ordering, your main concern should be whether an online pharmacy is sending customers what they ordered. Neither mifepristone nor misoprostol is a particularly expensive medication, and if some of the pharmacy's medications are legitimate, it is much more likely your own medication will be.

I have seen prices for mifepristone ranging from about \$8-10 per dose to around \$50 per dose, and \$2 to \$20 for misoprostol. You shouldn't pay more than this—if a pharmacy is charging \$100 or more for mifepristone or misoprostol, chances are that they are actually scamming desperate women and sending either sugar pills or no pills at all.

If you have enough money to do so, it is a good idea to purchase pills from two or three different pharmacies when you need abortion medication. That way, if one pharmacy has given you pills that don't work or fail to send the pills in a timely manner, you still have a backup.

Within six hours of taking misoprostol, you will know whether your pills were duds. Even an incomplete misoprostol abortion would lead to cramping and bleeding. If you are simply not feeling different at all, it's very likely that the medication you purchased is not actually misoprostol. Don't panic about receiving a medication that could hurt you: since every medication costs more than inactive pill ingredients, it is very unlikely that you would receive an active pill of some other medication. Instead, it's very likely that you received "sugar pills"—pills with no active ingredients at all, usually made of sugars and starches.

Twelve hours after taking a dose of "misoprostol" that turned out to be inert pills, you can try again with pills from another pharmacy. This gives you plenty of time to feel the effects of the misoprostol and verify that you are not double-dosing on active pills.

Pharmacies For Diaphragms

Diaphragms are non-prescription in many English-speaking countries, including the United Kingdom. Google searching for something like "buy diaphragm online no prescription" will generally yield good results, as there are not a ton of pharmacies involved in fake diaphragm scams!

Appendix B: Building Your Network of Trust

In today's legal climate, restrictions on abortion and contraception are quick to crop up and can take years to stop—if they ever stop at all. This means it's more important than ever to develop networks of trust with women you know.

What is a “network of trust”? Put simply, this is a group of women who want to help each other to ensure that people in their group of friends will be able to make reproductive decisions regardless of legal restrictions.

If you already know your friends to be pro-choice, you may believe it would be easy to build these networks. However, even pro-choice people can sometimes be hesitant to break the law in order to support the cause. If a pro-choice person is on the fence about whether or not to join your network of trust, feel free to share *A Womb Of One's Own* with them—and feel free to share the information that first- and second-trimester abortions are as safe or safer than giving birth. It's also important for them to know that the importation of abortion pills is not illegal, nor is taking the common ulcer medication Cytotec (misoprostol) that induces the abortion.

It is important to only allow people into your networks of trust that you believe will keep your secrets safe. While the vast majority of what you will be doing is legal, allowing people into your networks of trust who are not, themselves, trustworthy can create a host of problems.

Once you develop a network of trust, there's one important rule any time someone orders pharmaceuticals for emergency contraception, birth control, abortion, and so on: GET EXTRAS. Buy extra pills, stash them away, keep them for a rainy day or a woman you know who is in urgent need of them.

If any women in your networks of trust have connections to a country like India or Mexico, where misoprostol and mifepristone can be sold without a prescription, or to the UK where diaphragms are prescription-less, you may want to use these connections to find quality pharmaceuticals and import them quickly.